DEPARTMENT OF MEDICAID SERVICES
NURSING FACILITIES TECHNICAL ADVISORY COMMITTEE

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Kentucky Cabinet for Health
and Family Services
275 East Main Street
Frankfort, Kentucky

January 21, 2020,
Commencing at 1:02 p.m.

Tamara S. Duvall-McClain, RPR

A T T E N D A N C E

MEMBERS:

Terry Skaggs, Chair
Janine Lehman
Adam Lewandowski
Jay Trumbo
Sarah McIntosh
Stephanie Bates
Lisa Lee
Steve Bechtel
Amy Richardson
Lee Guice

MEMBERS PRESENT:

(See List Attached to Back of Transcript.)

CHAIRMAN SKAGGS: So, we'll call this meeting to order. And since I think there's some new folks as far as I know or the people I know, some new folks in the room, if we don't care could we do a quick introduction. We'll start our way around.

(Those in attendance introduced themselves.)

CHAIRMAN SKAGGS: The next item on the agenda is the approval of the minutes. There were two corrections, they're minor. On page 28, line 18, and page 29, line 2, it referred to the provider T-A-C-S instead of provider T-A-X. So with that, with those corrections, I think the minutes are in good shape. That's kind of picky, but, you know, I just wanted to point those out. Other than that, I think the minutes are good. I assume we need to approve them.

MR. TRUMBO: So moved.

MS. LEHMAN: I'll second.

CHAIRMAN SKAGGS: All right. All in favor, aye.

(Aye)

CHAIRMAN SKAGGS: Okay. All right.

We've got a list of issues here, we'll just take off with them. As we discussed in the past, we are -- we're pushing or we've referenced that we are in agreement to move forward with a provider tax increase, with the proceeds going to increase the price. Our association workgroup, the board approved a quality improvement plan to be utilized as a portion of that provider tax proceed for quality improvement. And we want to continue to pursue that plan to be implemented, hopefully, July 1 of 2020.

But we want to make sure that we get everything discussed and everything in place so that the Revenue Cabinet by June 1st can send out the 30-day notices to increase that provider tax in 2020. And, you know, with the changes, we wanted to bring it back up and see if that's something that the department is willing to work with us on, in trying to get that implemented July 1.

MS. LEE: And this is my third day on the job.

CHAIRMAN SKAGGS: Third day, we understand, we understand.

MS. LEE: This is the first time that I've been involved in some of these discussions, but I'll definitely make sure that that's elevated up to see what kind of discussion that we need to have going forward to get this in place.

Also, I guess one question would be how would that impact private providers or maybe providers that don't accept Medicaid patients, would they still have to pay the tax, would they have any sort of benefits?

CHAIRMAN SKAGGS: They do. And I'll just tell you that we're one of the organizations that has a facility that is predominantLY private pay. We're about 70, 75 percent in the facility that we're in. So basically, we pay more tax than we get back through our Medicaid rate. That goes all the way back to the implementation of the tax in the early nineties.

I will say as a private pay provider that we have the opportunity wITH the provider tax increase, to build that into our budget. Most of your private pay providers are going to be your high-end providers who

can charge, you know, 50 to a hundred dollars above the market rate to -- for those private individuals. And we can -- we can absorb that type of cost and that cost increase.

The way the provider tax is structured, you've got also your largest facilities who pay a step-down tax. You've got your smallest facilities who pay a step-down tax. And then your hospital base facilities that pay a step-down tax. Again, all of that was negotiated initially in the late eighties or early nineties when all that was implemented. We don't anticipate, in our association, any pushback from those private providers.

MR. BECHTEL: One thing that we need to point out is CMS has gone through a reorganization, so there's different people that we're going to be dealing with. So the sooner we can -- if that's where we're going, the sooner we start working on it, the better. Because I can't tell you that -- in the past, if we got an approval within 30, 60 days, I cannot guarantee that's going to be the case.

CHAIRMAN SKAGGS: Now, let me ask you this. The increase in the provider tax is within the current rules, the regulations, as I understand it. All we're doing is maximizing what we can potentially do. And it's already in the statute and already built into the regulations. The only thing that would really change would be the quality piece that we're looking at adding on the component; is that correct?

MR. BECHTEL: The quality piece, but you'll be changing your per bed amount.

CHAIRMAN SKAGGS: Right.

MR. BECHTEL: So, I would have to run those through CMS.

CHAIRMAN SKAGGS: Okay. I didn't realize you'd have to do that. I thought we could maximize out without a CMS blessing.

MS. LEE: Any time we change benefits to beneficiaries or provider rates, regardless of which provider type it is, we will have to do a state plan amendment.

CHAIRMAN SKAGGS: Okay. All right. But, again, we'd like to open those discussions so that, you know, there's no

roadblock between now and June 1st.

MS. LEE: Right.

MR. BECHTEL: Right.

CHAIRMAN SKAGGS: And we'll put a workgroup together, we'll meet privately, we'll do whatever we need to do to get that done.

MR. BECHTEL: Then -- and I apologize, I have to leave early to get on a call about the MFAR, Medicaid Fiscal Accountability Resolution, that's going on with CMS. And I sent that information to you, Wayne. I don't know if you've passed it on. But, you know, I'm not sure how CMS is viewing our current -- we got a waiver for the provider tax, but, you know, we do it at a tiered amount --

CHAIRMAN SKAGGS: We do.

MR. BECHTEL: -- based on enrollment. So, I don't know how they're going to view that based on that MFAR language, so that's something that's out there. I'm most concerned about the nursing facility tier than I am anything else right now.

CHAIRMAN SKAGGS: We did actually

discuss it at our board meeting last week. And, you know, we indicated we were going to be here this week and we would be discussing it. You know, I know -- I know if we go away from the tier, your 1285 for the bulk of the providers would probably come down a little bit, but everybody else would have dramatic increases if we had to get this to a level provider tax.

I do know at the American Health Care Association level, Governor Parkinson and the lobbyists up there are basically -- I think the focus on that from CMS were these IGT programs, like what Indiana has, where they've gone in and bought -- the hospitals have gone in and bought the facilities and made them hospital based. And they're just pouring billions of dollars into those programs.

HCA is trying to get the nursing facility provider tax carved out of that lookback. So, you know, it's not a done deal yet, but I do know that it's being discussed at the federal level. And what they are being told in their private discussions with

CMS is that it is -- it is a pushback against those very expensive IGT programs.

MR. BECHTEL: Okay.

CHAIRMAN SKAGGS: Anything else on that?

During the last TAC we did thank Medicaid for our July 1 increase. It was -- I tell you what, it was a much needed increase. Going one-tenth of one percent for five years, that -- it was a blessing to providers. I know we had requested, moving forward, to be paid a full inflationary adjustment to the capital and noncapital components going July 1 forward.

I know in the last TAC meeting -- which I actually wasn't here, but I've read the minutes. In the last TAC meeting, I know there were discussions about the preliminary numbers that were being put together for the budget. I know there's been a change in administration, a change in leadership, and was just looking for, you know, some general thoughts on where the inflationary adjustments are potentially going July 1 forward.

MR. BECHTEL: So, you're correct, in my -- in the department's recommended budget, or requested budget, I did put in around four percent to hopefully take care of any adjustments that we need to do. But, obviously, I have to wait to see what the Governor's recommended budget is from our requested budget and then we'll have to relook at it at that time.

CHAIRMAN SKAGGS: We assumed that.

MR. BECHTEL: Yeah.

CHAIRMAN SKAGGS: We were just wondering if we were still somewhat on track with similar thought processes as we're approaching the Governor's budget.

MR. BECHTEL: Yeah, I have not had a time to -- in three days to discuss with Commissioner Lee just yet to see where we're going with that. But like you said, we've done .1 for five years, then went to three this year. So, we did budget for it, we put it in our requested budget, but I have to wait until Tuesday the 28th to see what the Governor puts in his recommended.

CHAIRMAN SKAGGS: And, Commissioner,

Wayne has got information that he could share with you that shows during that five-year period of time, the one-tenth of one percent inflationary adjustment, what actual inflation did and kind of the hold that it has created for the providers. And that's part of the reason that we're coming in with the provider tax request and the funds coming back to the industry is to help close some of the holes that were created as a result of, basically, flat inflation for five years.

Thank you, appreciate it. And we kind of knew coming in that until the Governor makes his address everything is up in the air.

MR. BECHTEL: Yeah.

CHAIRMAN SKAGGS: We knew that.

Medicaid and PDPM. At the last meeting we discussed that the RUG 3 methodology would continue up until September 30th, 2020. Providers would like to know at this point whether the State's going to continue after October 1 of 2020, or if the decision has been made to switch to PDPM.

You know, it's an important decision.

We suggested, I think, at the last TAC meeting that we would put a workgroup together with association folks, Medicaid personnel, folks from Myers and Stauffer, whoever, if the next step is to implement the PDPM. Can you give us any indication as to whether PDPM will be implemented October 1? And, if so, can this workgroup or this potential workgroup begin working on implementation details?

MS. CLARK: I think what we discussed with the department is that it's really still too early to really move forward with that. Based on the assessments that Medicare has and the items that they have on those assessments, or lack thereof, there really isn't Medicaid data available to -- to analyze the PDPM yet. We're hopeful that on 10-1 the data that would be necessary for the Medicaid residents will be added to their assessments, but -- so, really, 10-1 is the earliest that we can start gathering data.

So, I think kind of what we recommended is the State, you know, take at least a year to gather information. You

know, certainly in the meantime I think it's having some meetings on what does it look like, a transition going forward, what would some change look like, but there just won't be the data right now to be able to model that. And so that's kind of what we're recommending.

You know, change is, I think, imminent. I think you all are probably aware that CMS is going to support what we need for RUG information. And Beth can talk a little bit more about the OSA process that we will need to start on 10-1.

CHAIRMAN SKAGGS: Which is next on the items, yeah.

MS. CLARK: So, you know, there will be some changes that we'll need to do for that so that we can still collect the RUG information. And CMS has said that they will continue to collect that, but that that isn't indefinite. You know, they haven't set a timeline, I think we're just kind of guessing maybe five years. That's, again, not in stone, we're just sort of projecting that, you know, definitely we need to move in a

different direction, and probably looking at the PDPM data and sharing that with DMS during that decision-making process.

But, you know, our recommendation would be on -- by 10-1 you need to have the OSAs in place, because RUG elements will be coming off of the assessments that exist.

CHAIRMAN SKAGGS: Correct.

MS. CLARK: And so I think actually what we've talked about with DMS is actually implementing the OSA starting July 1, so that -- so that there's a practice round, so to speak.

CHAIRMAN SKAGGS: Absolutely.

MS. CLARK: You don't want to wait until you need it and then something goes wrong and you're not collecting the information. So, I think we're recommending at least July 1 to be requiring the OSAs. And that would be for the PPS and the overassessments.

CHAIRMAN SKAGGS: I'm going to be a little tongue in cheek here. You must have had a little bug at our lunch table discussion, because that's one of the things

that we had in our recommendations. I'm just going to jump right on into item D, which is the removal of Section G from the subset.

I guess the biggest question that has come up about the OSA is, I mean, are we going to do an additional OSA and that will just set the Medicaid rate for an individual? Are they going to be quarterly, so that we're in a similar cycle like we currently are? Because we know that those four late loss ADLs are coming off of the current MDS with Section G going away.

And I actually have a copy of the State assessment, which has the items in it. And if we assume that we would need that to be able to do the implementation, kind of looking for your thought process on how it would be scheduled, how often it would need to be completed, et cetera, et cetera.

MS. CLARK: And I think that's something we'll definitely work with Medicaid on and be sure that we communicate out in advance. You know, we kind of involve our nursing team on the recommendations for a lot of this. So, you know, I was thinking that

the initial thoughts were, you know, it's submitted along with your regular assessments. So, you submit your -- all the overs, the five days, and then the OSA along with. But, again, I think we can work with the department and get some more information out about that process.

MS. LEHMAN: If I may, just one thought to consider --

MS. CLARK: Sure.

MS. LEHMAN: -- and I'm sure you're well aware of it. The OSA being a freestanding assessment, this is not something we can combine. So, it will have to be done as a separate assessment. So if we're doing that with every assessment that we do, including the PDPM assessments, that's going to increase the workload substantially for the MDS coordinators who have just kind of finally gotten a little relief with PDPM, because we don't have to do the 14-36-90, et cetera. We'd kind of be going back to what we were doing before. And I see that as a pretty significant burden to them right now, with staffing being the biggest crisis that

we face currently in Kentucky.

So, I just wanted to throw that out there, that being a standalone assessment, it's much different than when we were able to combine assessments and it wouldn't be duplicative work, so --

MS. CLARK: Okay.

MS. LEHMAN: Thank you.

CHAIRMAN SKAGGS: Any other comments on the OSA? I know we had a lot of comments at lunch. And literally, I mean, you must have had us bugged, because that's where we were headed was assuming that that would be the route that we would take.

MS. CLARK: Sure.

CHAIRMAN SKAGGS: The other discussion that we did have was some type of transition period so that we can get used to it, you can get used to it. We could actually do some modeling and gauging to make sure that, you know, we're still capturing what we need to capture to be able to get our RUG score.

MS. CLARK: Right, yeah. You know, and our firm has been heavily involved with

speaking with CMS. And I think, you know, the unfortunate thing is, is I think they got so far along before they really understood the impact to Medicaid. And, you know, ideally they would leave these items on the assessments until such time that we're kind of doing away. I think, unfortunately, they've already made the changes to their assessment so far out.

And so I understand, you know, the OSA isn't, you know, ideal as far as the burden, but at this point it's -- you know, maybe considerations of how often as you mentioned, but it is kind of the only option at this point, so --

CHAIRMAN SKAGGS: And I know you guys work with a lot of states --

MS. CLARK: Right.

CHAIRMAN SKAGGS: -- and their case mix systems. I'm assuming that most of those states are going to be pushing to add the OSA as well.

MS. CLARK: Correct, yes. For anyone that continues RUGS, they'll have to implement it.

CHAIRMAN SKAGGS: Okay.

MS. HUGHES: You mentioned a workgroup. I'll just caution you that it not be a workgroup of the TAC. You all can be on it, but if you do it as a TAC workgroup it has to be open record, open meetings.

CHAIRMAN SKAGGS: No, I understand. No, I understand.

MS. HUGHES: Okay. I just want to caution you.

CHAIRMAN SKAGGS: No, we were just looking at trying to get some of the focus from the associations, and I will put an S on that. I will let you know that there's supposed to be a representative from Leading Age on this Technical Advisory Committee. We've been without a representative for Leading Age for now a couple years.

MS. HUGHES: And I actually contacted Mr. Vino myself back maybe September, something like that, and have not -- that's not resulted in -- I thought when they named Mr. Dadds on the MAC, that that might -- he might roll into this committee, also, but hasn't happened yet.

CHAIRMAN SKAGGS: But what we were looking for, I think, was representatives from the associations, Medicaid, Myers and Stauffer, whoever, to sit down and just, you know, talk through the process and make sure that there weren't any significant issues as we move forward with this. And, again, I don't want to make it a formal workgroup of the TAC.

MS. HUGHES: Right.

CHAIRMAN SKAGGS: It's just providers sitting down with Medicaid services --

MS. HUGHES: That will work.

CHAIRMAN SKAGGS: -- and coming up with a plan. And making sure that there's been input from everyone and it's implemented appropriately. Yes, ma'am.

MS. LEE: It's basically a stakeholder engagement.

CHAIRMAN SKAGGS: I like that terminology. It's not one I would use, but I appreciate that. I like this terminology.

All right. Anything else on PDPM or the Section G changes, potential changes?

At the last -- go ahead.

MR. JOHNSON: I was going to ask, if it is implemented July 1, about how long do you think the notification period would be? How long would we know ahead of time that we were going to implement?

MS. CLARK: I think we could -- if DMS chooses to proceed with that, it could be early. Because I know, you know, your software vendors will likely need a heads up.

CHAIRMAN SKAGGS: Absolutely

MS. CLARK: You know, we will, obviously, within DMS and our RAI coordinator, you know, we'll have internal processing changes that will happen.

MS. VAIL: There will be some training, too, webinars, things like that.

MS. CLARK: Yeah.

CHAIRMAN SKAGGS: I will say our national software vendors have an idea it's coming.

MS. CLARK: I would think so.

CHAIRMAN SKAGGS: Yeah. And have probably done some preliminary work; even though clicking into my software I can't look and see one. But I'm going to say they would

be able to implement very quickly.

MS. CLARK: And I'm hopeful that they will have some solutions as well, as far as the effort needed when creating those, removing as much of the duplication as possible.

CHAIRMAN SKAGGS: All right. I think at the last TAC meeting it was indicated that KLOCS was back on track and targeted to be implemented April 1. There was a reference made that providers would be allowed a total of three days to enter the KLOC information in the system, which kind of alleviated our concerns on those late Friday admissions that, you know, were difficult to get into the system and to get the information in. That would give them until Monday to do that.

Then there was a reference in the October 2nd provider letter that the committee health centers were gathering information regarding the PASAAR two, which I think is probably one of our concerns at this point, especially with the Hospice folks. And when I say that, if Hospice is taking on the admission, we've got to make sure our

folks are doing the PASAARs, because it's not their responsibility. But they -- I think a provider letter announced that facilities had until November 30th to provide that information.

I guess what I'm asking here is, has the information been received from everyone, has it been entered into the KLOC system and are we still on target for April 1?

MS. GUICE: Yes, we're still on target, but it's going to be for April the 3rd, because that's the next -- you know, we have an implementation on Friday night and then --

CHAIRMAN SKAGGS: Got it.

MS. GUICE: -- it goes forward. The letter to gather the information, okay, we were trying to backfill data into KLOCS on who has PASAAR level two level of care and is currently in a facility. I cannot say that we got good information back from the facilities and/or the CMHC. So, we got what we got and we tried to put in what we could.

Apparently, we weren't clear about we only wanted folks who were alive and, you

know, maybe had gotten their PASAAR two in the last year or two, something like that, but -- so we got a lot of information. Some of it we could use and some of it we couldn't. The only purpose is to try to start building some historical data into the system. And that has to be cleaned up, and looked at, and validated as far as the data part goes. So that's why we went ahead and were asking for that back in November.

CHAIRMAN SKAGGS: Is there anything we can do to try to push that information from the provider? I know Wayne did a really good job of sending out information to our membership. I know from my standpoint, I reached out to our facilities and tried to encourage, et cetera, et cetera. But I'm amazed at the number of people that don't read either your provider letters or his provider letters. And, you know, they're kind of in an island to themselves. And when you start discussing this stuff with them they look at you like you've got two heads.

So, I guess I'm asking, is there anything that we can do to help push this, or

have you got it where it is and --

MS. GUICE: We have it where it is and we don't have the resources now to go back and try it again.

CHAIRMAN SKAGGS: Again, okay.

MS. GUICE: I'm not sure that it's going to be a big problem going forward given all of the duplicative work that continues today in the current system, so -- and I say that because I think PASAAR level two is a perfect example of that, where I come into a nursing facility and simultaneously you do a PASAAR level one and the LOC request, PA request from CareWise. And PASAAR one triggers a two.

Well, the workflow should be that if a two is created, or if a two is triggered, CareWise doesn't do anything. It should be doing nothing at all. Because the CMHC folks are the ones who actually make that level of care determination.

So now we have like three sets of processes going at this point in time. So, we'd likely have most individuals in the facility -- I'm quite sure that if you have

somebody in your facility that you're not getting paid for, that we're hearing about it and trying to, you know, take care of those issues. It's just that we may not have them marked as having a PASAAR level two.

CHAIRMAN SKAGGS: Okay.

MS. GUICE: And one of the other issues about that is a reassessment. Once you have a PASAAR level two, you don't need a reassessment by CareWise, because they're not qualified to make that decision. They're not behavioral health folks, in other words.

CHAIRMAN SKAGGS: Right.

MS. GUICE: And so we do have facilities calling and asking for reassessments on PASAAR level two. And when CareWise comes to the facility to do their six month, should have been annual since August, reassessments, they're reassessing them based on their clinical criteria as well, okay, so --

CHAIRMAN SKAGGS: Okay.

MS. GUICE: -- duplicative work once again. So some of that will be teased out and should be easier on everybody. And

eventually we'll have all the people that have -- it might take us a couple years, but eventually our data will actually be good.

CHAIRMAN SKAGGS: I'm assuming there's a process in place -- once we implement the new KLOC system and all that, there's a process in place where if the provider's not getting paid, or approved or whatever the case may be, and it's because of the level two PASAAR and they've got one, there's a way they can communicate that and get it into the system.

MS. GUICE: Okay, it is. There's a workflow inside the system for level two.

CHAIRMAN SKAGGS: Okay.

MS. GUICE: So if the information I create on the PASAAR one triggers a level two, it's an automatic process.

CHAIRMAN SKAGGS: Okay.

MS. GUICE: And that's where the request goes, is to the folks who handle PASAAR level two evaluations. And that will be done, okay. And they have a workflow process to flow back. So that also will give us the ability to see are they being timely,

are they appropriately sending back the information, et cetera, so we'll be able to look and see.

And you will be able to look and see where your request is. If you've hit the button and it's gone, it will tell you where the task has gone to and you'll know when it left.

CHAIRMAN SKAGGS: Okay. That's -- and I'm trying to understand all this.

MS. GUICE: I know, it's hard to visualize.

CHAIRMAN SKAGGS: That's April 1 and forward.

MS. GUICE: Uh-huh.

CHAIRMAN SKAGGS: What about the folks that are coming in, that are already in our building coming -- coming in and coming up for, you know, recertification of their Medicaid and all of that. If there's any issues with those prior to April 1, I assume there will be a process in place that the provider can reach out and say, yes, we have the PASAAR level two and --

MS. GUICE: Sure.

CHAIRMAN SKAGGS: -- it wasn't in the system, et cetera, okay.

MS. GUICE: Sure. I mean, you have a process today to reach out if something's wrong.

CHAIRMAN SKAGGS: Okay. All right.

MS. GUICE: Just now we're going to be able to look into the system and see where it is ourselves, all of us, which will be good.

MS. McINTOSH: So as far as training dates --

MS. GUICE: Okay, so -- thank you for the nice segue. Behind me, Laura with Deloitte is leading the training program. We're in the planning stages. There are some -- I brought this so you could see it, but not see it. Okay?

CHAIRMAN SKAGGS: Got it.

MS. GUICE: It's the draft KLOCS training approach. We started working on it the end of December. It's being hammered out now. It should be released -- when do you think? Two weeks?

MS. COMBS: Uh-huh, yeah.

MS. GUICE: Wayne, thank you for coming, because I want to introduce you to Laura in case we need to ask for some training facility assistance. We're going to be training all of the facilities in several regional trainings across the State.

CHAIRMAN SKAGGS: Thank you.

MS. GUICE: And there will also be some webinars that will be available for, like not really make-up training, but reference material.

MS. COMBS: Yeah. So, we're talking through -- they call them sometimes like micro training videos, where maybe I just need to know how to upload a document. It's like a thirty second, one minute clip. We can do like a longer one, but we understand people in the facilities are busy. So if we can get the key bits of functionality that they need to know about, then they're able to go and quickly watch the video so it doesn't impede their workflow.

CHAIRMAN SKAGGS: Well, and you can go to those regional trainings and make all the notes that you want, but the first time

you put your finger on the mouse and start to click it's like total brain freeze. So, yeah, those would be very helpful.

MS. COMBS: I think we're planning to do trainings before go live, as well as offer some make-up sessions afterwards too. So go back to Louisville, Lexington, Owensboro, so if anyone couldn't get to those trainings beforehand, they have the opportunity. Or once they get in the system, if they have additional questions, we understand, so --

MS. GUICE: And we're trying not to train too early or too late.

CHAIRMAN SKAGGS: And I understand that as well.

MS. GUICE: Just exactly the right time. Just exactly the right time. And are we still training -- ICF, IDDs will be in the room training?

MS. COMBS: Correct. Hospice, nursing facility.

MS. GUICE: So, we'll all be in the same room, along with some CMHC folks, maybe.

MS. COMBS: I think we'll also have materials available, because we understand

the facility may send their own trainer. So, they may have someone go, and they'll go back to the facility and train their own staff. So, we're thinking through like a train-the-trainer guide, get them some supplemental materials to help them as well.

CHAIRMAN SKAGGS: That would be very helpful. I know most of us utilize folks like Sarah and their CPA firm for, I guess, supplemental work, backup works, backup training, et cetera, et cetera. So, you know, getting those folks and folks like at our corporate office those train-the-trainer type materials, you know, we have turnover like everyone else. And there's going to be somebody two months down the road that didn't go through the training, and it will be helpful, we appreciate that.

MS. GUICE: So, we're trying. We're doing our best to lay out a good plan, one that will be very beneficial, but also doable, you know, given that we don't have unlimited resources. I'm still just -- I know this is a big change, I know it's a big change for everyone. But I'm still very,

very hopeful and believe with all of my heart that this is really going to be a very big improvement over what we're all currently dealing with today. And the improvement will be on all sides, your side, our side, the UM side, every possible way I can think of, so --

MR. JOHNSON: I get a lot of calls from providers anxious for that to occur. So, they view it as a good thing too. There's, I think, like you mentioned, maybe cut down on CareWise's work, you know, because things will be tasked maybe differently than what they're getting now. So, they're looking forward to it, so we're anxious too.

One of the reasons why it was on the agenda, to see if it will -- will it actually kick off on April 3?

MS. GUICE: We're on task for that, we're still on point for that. We've got a lot of implementation plans already laid and set. And while we're coming through there will be a lot of changes. So, we're going to be talking about those changes mostly in the

trainings. But there will be some changes that we'll make on the inside that won't necessarily impact how you do business today, but then somebody might say something to you. So, I'm putting together a communication to go out to all the providers about that.

And, you know, if I say something now before it's in place and before the communication's in place, it will just create -- I don't -- no confusion needed. But there will be a -- besides the training, there will be an additional letter that will go out.

MR. JOHNSON: We have our next TAC meeting on April 7, so we can follow up then.

MS. GUICE: Oh, good. So, we'll be reaching out to ask, you know, for some help with distribution, too, sometimes --

MR. JOHNSON: Yeah, that's not a problem.

MS. GUICE: -- if we have some information we want to send out. I appreciate that.

CHAIRMAN SKAGGS: All right. Anything else on that? Thank you.

I know at the last TAC it was referenced that providers were not able to modify information within the Benefind system upon admission when the residents had already qualified for Medicaid benefits. The issue is, I think, contributing to Medicaid pending problems down the road.

In the meeting I think, Lee, you had indicated upon admission, if the provider has assigned MAT 14 and sends it to DCBS to have them as associate to the Medicaid beneficiary, that DCBS should be able to do -- do it unless there's a mismatch. If a mismatch occurs, I'm not going to go into all of that.

MS. GUICE: Sure.

CHAIRMAN SKAGGS: Is there a possibility that we could set up a meeting with some system terminals, and we can send some folks from Sarah's billing workgroup so we could educate providers on how to use the Benefind system upon admission, especially for those folks that already have Medicaid and are coming into our facilities.

And you had mentioned something at

lunch about some folks that had indicated there is a way to do it, but --

MS. McINTOSH: I've got one Medicaid liaison for some nursing homes and he is using the Benefind for those patients that are in the community and he's able to make it work. But he was somebody that was on the inside with you guys and has experience. So, he's able to work with the caseworker, his caseworker, and it's working. He said, you know, it is complicated.

But most of my facilities, they don't have that knowledge base. So, they really seem to be struggling with what to do when they have an issue with that patient that's in the community and comes in to apply for Medicaid. So then, therefore, that leads to they're just not using Benefind at all. And I really think that's a loss for all of us.

CHAIRMAN SKAGGS: Yeah. And they're sending them down to the local office, which could potentially be understaffed. I know we've had some of the offices that we work with that have had some pretty significant retirements and they're in the process of

training those folks. And we're starting to see back-logs again in some of those areas as a result of these folks having to go down and make the application versus the Benefind system.

MS. GUICE: Okay. I'm a little confused about not being able to make changes once you've been associated to the case.

CHAIRMAN SKAGGS: I'm going to let you speak to that.

MS. McINTOSH: Being associated. Are you talking about the MAT 14?

CHAIRMAN SKAGGS: Right.

MS. GUICE: As an authorized representative can you not go in and work with the case or --

MS. McINTOSH: It seems to be when the patient is in the community and comes to the nursing facility, there was a real railroad there. And I'll be honest with you, I have not personally done it.

MS. GUICE: Okay.

MS. McINTOSH: But it seems to be that's where it was a mismatch, a partial match, the full match.

MS. GUICE: Okay, got it.

MS. McINTOSH: And that's where the facilities were really having some confusion. And I know when I spoke with the gentleman that is currently doing it, he said it is -- it's accomplishable, he said but I -- it's only because he said I feel like I know both sides and I can ask for assistance.

CHAIRMAN SKAGGS: Talk the language.

MS. McINTOSH: Yeah.

CHAIRMAN SKAGGS: Trust me, we would love to use the system. And if we can figure out how to make it work, I know our facilities would be all over it. Because, you know, when you're running them down to these local offices, we're at the family's mercy to be able to get that information. Where if we're gathering that information ahead of time and getting it into the Benefind system for them, we know it's there.

MS. GUICE: So there are a couple of things. One, I want to back up just real quickly to KLOCS.

CHAIRMAN SKAGGS: Okay.

MS. GUICE: Okay. I know that,

Sarah, you're probably going to remember going through this maybe. Remember when you onboarded and opened an account in COG so you could become a, shoot, authorized representative. That processes is how we're going to onboard you again for association into KLOCS. I just want to say that.

Shouldn't be that difficult. I don't know yet if the people we currently have in the system, that we could just move you, we're still looking at that. I forgot to say that before.

The other thing, member mismatch is always kind of difficult. It depends on how whoever typed it in, and how they typed it in, and it can be an issue. And, yes, I think a lot of problems occur when you all speak your language, the caseworkers speak their language, and then you come and ask me a question and I speak, you know, my language. So to that end -- and not just for you all at all, but in order to assist with hopefully making the self-service portal a little bit easier to use, there has been an effort to look at the self-service portal to

see if we can make it more user friendly.

That's all I can tell you about that right now, because that's not my project. But I do believe there is a will to make that easier. Because everyone understands that it's difficult to get into the office, and to talk to a worker and all of those things. That's why we pushed it out is so that people could do their own -- make their own applications. They could change their own information when they need, they can recertify when they need to. So that's good.

If I could ask a question, do you all get folks into your facilities for rehab only? Do you know that, do you?

CHAIRMAN SKAGGS: At times, yes.

MS. GUICE: Do you apply for an LOC for those individuals?

CHAIRMAN SKAGGS: Do you know the answer to that?

MS. McINTOSH: I would say the majority of the time we do.

MS. LEHMAN: We try to, because we never know for sure if they're going to become long-term. And we're trying to ward

off that where we're not notified until it's too late. So, we are trying to do that on as many as we can, yes.

MS. GUICE: So if somebody comes and asks for admission or they're coming into your facility and they have an MCO, do you do -- do you ask for an LOC then, or do you know?

MS. LEHMAN: I think we're trying to do it on the majority of residents, because there have been cases where they've changed from the MCO to straight Medicare and, again, didn't notify us of it. So, we're trying to do it on all residents.

CHAIRMAN SKAGGS: On admission to the facility, it's my understanding they can opt to move from the MCO back to traditional Medicaid -- or Medicare.

MS. GUICE: Sure.

CHAIRMAN SKAGGS: Which the traditional Medicare tends to pay better in the nursing facilities than some of the MCOs do. Your MCOs are wonderful out in the community, but some of them are not that great when they come into the long-term care

setting. And a lot of those residents will immediately opt to go back to traditional Part A.

MS. GUICE: I'm just trying to learn a little bit about that process, to see how we're going to fit that in. Okay, thank you.

CHAIRMAN SKAGGS: Thank you.

MR. JOHNSON: I think it would be, if I can, Lee, beneficial to have that workgroup or a grouping of the Medicaid billing folks work with DCBS folks. Because I think that may be, you know, like you say, we're speaking one language, DCBS speaks another language, and you've got another language, and we all need to learn to speak French so we can all talk to each other.

But I think that would be helpful if we had that group, to maybe include DCBS to see where the barriers are. And I was telling Sarah, I think that most providers now have kind of given up on working with Benefind, because I -- I would say, and Jay and Adam could probably correct me, but probably 70 to 80 percent of the Medicaid admissions are those that have benefits

already. So like was pointed out last time, we're not going through the eligibility process to get them Medicaid. We're just going through the eligibility process to allow them to have long-term benefits.

CHAIRMAN SKAGGS: Versus community.

MR. JOHNSON: Right, versus community, so -- and the system is hard to do. It's not impossible, as we're learning, but it's hard to use. And that's really what we're trying to just make simpler for everyone's benefit. I don't know how to go about that. We can have off-line conversation, whoever I need to speak with to -- you know, to set that up, but I think that would be beneficial.

MS. McINTOSH: I do feel like it would help, too, with everyone, and I know the staffing issues with you guys and with us as well, the gentleman that I spoke with that is using Benefind in his facilities, he said that about 70 to 75 percent of his Medicaid applications, he is able to do those through Benefind. So that could remove the amount of people that are at the DCBS office as far as

eligibility.

CHAIRMAN SKAGGS: It gets them into the system.

MS. McINTOSH: Right. So, I do think it is going to be a huge benefit if we could just learn and implement that with our facilities.

CHAIRMAN SKAGGS: Yeah, I think our office staff is your best frontline for gathering that information. I know we work with one large facility in Western Kentucky, the office manager literally has taken the responsibility for all the Medicaid applications from the residents. The residents' families, they just pretty much bring everything in to her. She's got a checklist, she goes through it, then she makes the appointment with the local DCBS office. She makes sure that she's got everything in hand when she walks in.

If she was able to do that directly into Benefind, I mean, it would just make life that much easier, it really, really would. And if those folks, if those bookkeepers, if those office managers,

whatever their title is, if they know that they've got all that information and are ready to go in Benefind, it's a whole lot easier than the person going down to that local DCBS office without anything in hand.

They get handed a checklist and then you're fighting with them, trying to make sure that they're getting everything pulled together and taken down there, only to find out two months later they still haven't delivered that one life insurance policy that's holding up the entire application. Okay.

MS. GUICE: Understood. One quick question, Terry, back to you.

CHAIRMAN SKAGGS: Yes, ma'am.

MS. GUICE: You talked about that a lot of people come into the facility with an MCO and they switch to traditional Medicare. Did you mean traditional Medicare, not Medicaid?

CHAIRMAN SKAGGS: I thought I said Medicare, I'm sorry. Medicare A, yes.

MS. GUICE: Yeah, you did mean that.

CHAIRMAN SKAGGS: Yes, Medicare Part

A.

MS. GUICE: I just wanted to double-check. I'm making myself a note. All right, thanks.

CHAIRMAN SKAGGS: Again, they have that option when they come in.

MS. GUICE: Sure.

CHAIRMAN SKAGGS: And what we have found, and what all providers, I think, have found, is there are so many of the MCOs that are picking and choosing the providers they're willing to contract with. Therefore, you have a lot of providers that are out of network. And, as a result, it's better on the recipient if they convert back to traditional Part A Medicare for their benefits versus staying with the MCO and being out of network at, you know, reduced benefit. That's what we're running into in a lot of situations.

Your Humanas of the world, your --

MS. LEHMAN: Anthem.

CHAIRMAN SKAGGS: -- Wellcare, some of those are -- they're not contracting with every nursing facility in the State, they're

picking and choosing. And, as a result, if you come in with a Humana MCO, that particular provider may not be in network. Therefore, the out of pocket going to the individual is higher, unless they go back to traditional Medicare Part A. And then at that point in time they go back to traditional benefits with, you know, your regular co-pays, et cetera, which would eventually come over to Medicaid.

MS. GUICE: After 20 days.

CHAIRMAN SKAGGS: After the 20th day, yes. All good? All good. Are we good? I see you looking at your watch.

MEMBER: You're going fast.

CHAIRMAN SKAGGS: I'm a preacher's kid, so I've got the gift of preach.

Since our last meeting there have been some reports from providers, and Wayne can give specifics here in just a moment, who've indicated that they're having difficulty getting Medicaid approved transportation providers to take Medicaid patients to dialysis centers for needed treatment. The association is working to

meet with the Ambulance Association to try to see if we can reach a solution, but there are providers that have had to pay for transportation services privately for individuals that are covered under Medicaid on occasion. I think Wayne's got one example of a provider that spent over $16,000 transporting someone back and forth to dialysis.

I guess the question that we're looking for here is should providers have problems with transportation issues, is there a contact at Medicaid that we can provide to them -- excuse me, or -- go ahead, ask the question. I'm reading your notes.

MR. JOHNSON: I have -- I mean, transportation has been an issue, both emergent and nonemergent, for years and years. And I would get calls, and I typically contacted someone with the transportation department if there was a broker -- if there was an issue with one of the transportation -- contracted Medicaid transportation providers.

MS. GUICE: And that still would be

the case.

MR. JOHNSON: Okay. And that's really the question. Because rather than, I guess, me getting in the middle of trying to assist, I thought it might be good to get, you know, a person or a number, you know, where they can go if there is an issue.

And a lot of times the issue for nonemergent is someone is needing to get transportation to a doctor's office. Or there have been cases where they go get transportation to an emergency room or a hospital, and then they go late and it's beyond the hours that the transportation provides transportation, and they're left there. So that sort of issue pops up. But really where --

MS. GUICE: Okay. So if they go to the emergency room?

MR. JOHNSON: I'm sorry.

MS. GUICE: Did you say they go to the emergency room and then --

MR. JOHNSON: Well, if they go to the emergency room, they're probably going to have emergency transportation.

MS. GUICE: I hope so. We shouldn't be providing regular transportation to the emergency room.

MR. JOHNSON: Even with emergency transportation I think some folks have been left.

MR. LEWANDOWSKI: I'll give you an example of what a nonemergent would be. Dialysis is usually --

MS. GUICE: Sure.

MR. LEWANDOWSKI: Federated is the provider up in Northern Kentucky. You know, for whatever reason, the bus never shows up. You know, we figure out a way to get the resident back to the facility. But it's not an uncommon occurrence where a resident is at an appointment and nobody's ever there to pick them up.

MS. GUICE: Okay. Well, there's an 800 number to call with complaints like that. Have you -- do you have that? Have you used it and you're not getting any results?

MR. LEWANDOWSKI: Personally, I've used it. I'm not sure, you know, with reference to Wayne and whoever, I've used it.

I've contacted it many, many times.

MS. GUICE: And?

MR. LEWANDOWSKI: You get somewhere and then you don't get somewhere. And it's an off-and-on kind of thing. But as far as me reaching out, I've probably done it once in the last three months. Lately it's been a good thing.

MS. GUICE: Okay. Well, that's good. That's good to know.

Okay. Medicaid has had an issue through our transportation benefit period with nonemergency stretcher providers.

CHAIRMAN SKAGGS: That's the facility --

MS. GUICE: So nonemergency stretcher, it's not a Medicaid or Department of Transportation issue. Well, it is kind of a Medicaid issue. But we do not have enough ambulance providers who will provide that service, and they're the ones with the stretchers. So, we're looking at it.

I don't know -- right now I can't tell you exactly what to do, other than to call the 800 number. Or I'm going to give

you an e-mail address, someone in Medicaid that you may send an e-mail to if you have a specific complaint about this. So, we need like specifics. I advise you to please call that 800 number. We monitor that report on what those issues are that come through there, and we'll address those issues.

And I don't know what it is right now. I'll have to send it out to Wayne, I'm sorry. But Eddie Newsom is our branch manager who is responsible for nonemergency medical transportation. So if you have a complaint that you can't get -- or you're not getting satisfaction through the 800 number, you may certainly e-mail him. Please have some specifics for him to run with and he will take care of it.

MS. JOHNSON: Do you think you don't have enough stretcher providers providing nonemergency transportation due to reimbursement issues? Because we know -- I believe the Ambulance Association is pushing through a provider tax this session. I don't know where you all stand on that. So, I think they're trying to get a provider tax.

I know that there was an effort to kind of loosen up the CON laws. I think that's been now pulled back to allow for certain counties to get more ambulance providers.

So, I'm just trying to figure out is it a reimbursement issue, or is it simply a fact you don't have enough ambulance providers out there to provide the service?

MS. GUICE: So when I pick you up and take you to dialysis, I have to be able to have somebody there to pick you up from dialysis and take you back. So if we -- regardless of what we pay, that takes you out of your ability to respond to emergencies. And that's a problem.

MS. JOHNSON: We had a panel at our annual meeting, and it was standing room only, because our providers were very interested in trying to figure out what the issue is. And I remember them saying that, but -- and I think they get reimbursed more. Of course, emergency is emergency, it should be priority. But I think there's an issue with reimbursement and probably the number of vehicles we have on the road.

MS. GUICE: Sure. In a lot of counties you've got -- it's a private, but contracted with the county. And they have one company and they have two ambulances.

CHAIRMAN SKAGGS: I mean, even Daviess County, as big as it is, has one ambulance provider.

MS. HUGHES: Woodford only has two ambulances, or they did a couple years ago.

MS. GUICE: So, it's just a problem, it's a problem all the way around. And isn't everything tied to reimbursement, eventually? That's the thing --

CHAIRMAN SKAGGS: If you're going to be in business, you've got to get paid.

MS. JOHNSON: Yeah, you've got to be paid.

MS. GUICE: Yeah.

MR. JOHNSON: So, Lee, I typically call Eddie for nonemergents, and then Becky Downing -- or Downey I should say for emergency. And then also Jeremy Thompson is who I call.

MS. GUICE: Jeremy works at the Department of Transportation, right.

MR. JOHNSON: I've contacted him about --

MS. GUICE: Yes, all of those names are still good.

MR. JOHNSON: Okay. So, we can -- we could provide that information out to folks, but those are folks that I've called periodically. And they always do a good job responding when I try to correct the situation.

MS. GUICE: So if you send Eddie's name out to everybody in the State, though, he won't be able to respond to you. Now, if you could kind of like funnel information to him.

CHAIRMAN SKAGGS: Yeah, we could have them contact Wayne.

MR. JOHNSON: Yeah.

MS. GUICE: Absolutely.

CHAIRMAN SKAGGS: With specifics.

MS. GUICE: Yeah, that would be great.

CHAIRMAN SKAGGS: That can be shared.

MS. GUICE: Yes, please. I just want to point that out, we only have one Eddie.

CHAIRMAN SKAGGS: We get that, we really do.

MS. HUGHES: That's reimbursement, also, isn't it?

MS. GUICE: Yes, that is about reimbursement as well.

CHAIRMAN SKAGGS: Anything else? We have reached the end of the agenda. Anything from our -- Medicaid or anyone?

MS. LEE: I have nothing at this time. Does anybody else have any additional items?

CHAIRMAN SKAGGS: We would like to welcome you to your position.

MS. LEE: Thank you.

CHAIRMAN SKAGGS: Look forward to working with you. Like I say, I can find letters with your name on them somewhere in my files, I guarantee it. But we appreciate you. I'm sure we'll have some direct conversations in the near future. If all minds are clear, the next meeting date --

MS. HUGHES: If you're planning on coming to the MAC meeting Thursday, take notice, the meeting has changed locations to

Transportation Cabinet Auditorium.

CHAIRMAN SKAGGS: Okay, thank you. The next meeting is April 7th. If all minds are clear, we stand adjourned.

(The meeting concluded at 2:03 p.m.)

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STATE OF KENTUCKY)
) SS:
COUNTY OF JEFFERSON)

I, TAMARA DUVALL-McCLAIN, a Notary Public within and for the State at Large, my commission as such expiring on February 13, 2020, do hereby certify that the foregoing meeting of the Nursing Facility Technical Advisory Committee was taken before me at the time and place and for the purpose stated; that the meeting was reduced by me to shorthand writing and transcribed by me with the aid of a computer; and that the foregoing is a full, true and correct transcript of the said meeting.

WITNESS my hand this the 3rd day of February, 2020.

/s/ Tamara S. Duvall-McClain
TAMARA S. DUVALL-McCLAIN, RPR
Kentucky CCR No. 20042A138
Notary Public, State at Large
Kentucky Notary ID No. 549592